PHYSICIAN CANCER REPORTING FORM

Form TR-003
Revised 11/08

Reporting Physician and Address	Physician Phone	Date Form Completed	Date Received by MCTR
	Physician License or NPI #	Form Completed By	

PATIENT INFORMATION

Name of Patient Last First Middle Maiden Alias | Name of Spouse/Parent

Social Security Number | Date of Birth | Age | Referred From | Referred To

Race ☐ White ☐ Am. Ind ☐ Black ☐ Asian ☐ Unk ☐ Other _____ | Hispanic Ethnicity ☐ Yes ☐ No ☐ Unk | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Div ☐ Widow ☐ Sep ☐ Unk

Physical Address No & Street City County State Zip Code | Place of Birth

Telephone Number | Family History of Cancer ☐ Yes ☐ No ☐ Unk | Tobacco History ☐ Never ☐ Cigarette ☐ Pipe ☐ Chew ☐ Previous Use ☐ Unk | Alcohol History ☐ Yes ☐ No ☐ Previous ☐ Unk

Primary Payer | Usual Occupation | Usual Industry

CANCER INFORMATION

Date of Initial Diagnosis | Primary Site | Laterality ☐ Not Applicable ☐ Right ☐ Left ☐ Unk | Other Primary Tumors

Physical Findings (x-ray, scans, scopes)

Pathology (Histology and Grade) (attach copies of reports)

Size of Tumor

Lymph Node Involvement

SEER Summary Staging
- ☐ In-situ
- ☐ Local
- ☐ Regional DE*
- ☐ Regional LN*
- ☐ Distant*
- ☐ Unknown

* Describe: _____

For Melanoma
Depth of Invasion (Breslow's): _____ Ulceration: ☐ Yes ☐ No
Clarks Level: ☐ I ☐ II ☐ III ☐ IV

For Prostate
PSA Level prior to bx: _____

For Breast
ERA/PRA Status: _____

TREATMENT INFORMATION

Surgery ☐ Yes ☐ No	Radiation ☐ Yes ☐ No	Systemic Therapy ☐ Yes ☐ No
Type	Type and cGy	Agents
Date	Date Started and Ended	Date Started

OUTCOMES

Status

Date of Last Contact or Death _____

Vital Status ☐ Alive ☐ Dead Cancer Status ☐ No Evidence ☐ Evidence ☐ Unknown

Cause of Death _____ Place of Death _____

Physicians

Surgeon _____

Following _____

Other _____

Please submit supporting text/documentation (e.g., pathology reports, radiology findings, pre-operative H&P, etc), to verify diagnosis, staging, histology, treatment, etc.

Please mail this form and documentation to the Montana Central Tumor Registry, PO Box 202952, 1400 Broadway, Room C-317, Helena, MT 59620.

Or fax the reports to (406) 444-6557. For questions, contact the MCTR at (406) 444-2618. This document is also on www.cancer.mt..gov.